



**CONSENT TO DESTROY MY CRYOPRESERVED SPERM STORED
AT THE VIRGINIA IVF AND ANDROLOGY CENTER**

I, _____, hereby request that the Virginia IVF and Andrology Center destroy all of my frozen stored sperm. I understand that this completed form must be *notarized* and mailed to Virginia IVF and Andrology Center, 9030 Stony Point Parkway, Suite 390, Richmond, VA 23235. I understand that upon receipt of this completed form, the Virginia IVF and Andrology Center will no longer charge me for the storage of my specimen(s).

Patient's Signature	Social Security Number	Date
Notary Signature	Date	Commission Expires

For VA-IVF & Andrology Center Use Only

Date Received: _____	Received By: _____ <small style="text-align: center;">VA-IVF employee signature</small>	Date Destroyed _____	Andrologist:: _____ <small style="text-align: center;">VA-IVF andrologist signature</small>	Verified: _____ <small style="text-align: center;">VA-IVF employee signature</small>
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